Little Traverse Bay Bands of Odawa Indians

Childcare Assistance Application

To be considered for childcare assistance each question should be fully and accurately answered. No action can be taken on this application until all required information is submitted. PLEASE PRINT except for your signature. All information contained in this application is confidential.

NAME:_____ TRIBAL AFFILIATION_____

ADDRESS:_____ ENROLLMENT #:_____

CITY/STATE/ZIP:_____ SOCIAL SECURITY NUMBER:_____

COUNTY:_____ PHONE #: (_____)_____

RELATIONSHIP TO CHILDREN PARENT FOSTER PARENT

REASON FOR CHILDCARE:____EMPLOYMENT_____SCHOOL_____TRAINING

CHILDCARE NEEDS

List the number of weekly hours needed for childcare services during the school year and during the summer.

CHILD'S NAME	DOB	GRADE LEVEL	SCHOOL HOURS	SUMMER HOURS

HOUSEHOLD COMPOSITION

List all individuals other than the applicant and the children listed above who are living in the household. This includes spouse, significant other and all other children between the ages 13-18. Include the relationship to the children listed under childcare needs.

NAME	DOB	SOCIAL SECURITY #	RELATIONSHIP TO CHILDREN	LTBB ENROLLMENT #

HOUSEHOLD INCOME VERIFICATION

If you are a foster parent please proceed to provider information section

EARNED/UNEARNED INCOME INFORMATION

Beginning with applicant, list all earned GROSS income for all parents in household.

NAME	EMPLOYER	PAY FREQUENCY	MONTHLY GROSS
NAME	**SOURCE OF INCOME**	**PAY FREQUENCY**	**MONTHLY GROSS**
		TOTAL GROSS INCOME	**$**

SCHOOL/TRAINING

NAME	SCHOOL	SEMESTER

PROVIDER INFORMATION

Provider Type:

_____Day Care Center _____Relative Care ____Unlicensed Non-Relative_____Group Home

Provider Name:_____

Provider Address:_____

_____

Provider Telephone:_____

APPLICANT CERTIFICATION

I certify that all answers given are true, complete and correct to the best of my knowledge. This certification is made with the knowledge that the information will be used to determine eligibility for the LTBB Child Care Assistance Program. I agree to report all changes in my household composition and income within 10 days of when the date of change occurs.

SIGNATURE_____ DATE_____

RIGHTS AND ACKNOWLDGEMENTS

- **APPLICATION** I understand that I have the right to file an application for child care services. I understand that I must provide all necessary documentation for my application to be considered. Incomplete applications will not be accepted. I understand that I will receive notice regarding my approval or denial of services within 10 days of receipt of a completed application including all supporting documentation from the LTBB Department of Human Services.
- **AUTHORIZATION FOR SERVICES** I understand that I am responsible for all child care expenses incurred prior to my application being approved and an approval letter being sent to me. This includes all pre-existing childcare bills that I may have with my childcare provider.
- **NON-DISCRIMINATION** The Little Traverse Bay Band of Odawa Indians Child Care Assistance Program will not discriminate against any applicant because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If I believe that such discrimination exists I have the right to file a complaint with the LTBB Department of Human Services.
- **REPORTING CHANGES**
  I agree to report any changes in income, composition of household, changes in childcare provider or other circumstances that may affect my eligibility within 10 days of when change occurs. A "Change of Information" form must be completed and submitted with every change.
  I understand that failure to report all changes; especially financial, will result in my termination from the program and any outstanding payments will be my sole responsibility.
  I understand if I have not actively participated in the LTBB Child Care Assistance Program for a period of 60 or more days, I will be required to complete a "Reinstatement Form" and provide required documentation.
- **REPAYMENT OF BENEFITS** I understand that if I receive more benefits than I am entitled to receive through my own or LTBB's error, I must repay any benefits received to which I was not entitled.
- **AFFADAVIT** I affirm that all of the information provided in this application is true and understand that providing false information will result in my termination from the program. Deliberate misinformation that results in obtaining benefits to which I am not entitled may result in prosecution.
- **RELEASE OF INFORMATION** I hereby give my permission to LTBB to contact my designated child care provider to give notice of eligibility and contact the Michigan Department of Human Services for the purpose of verification of dual participation.
- **RECORD KEEPING** I understand that I must document childcare hours on a timesheet on a weekly basis and that I must submit timesheets at a minimum of every 30 days. I understand that LTBB Human Services will only pay 30 days retroactive from the date timesheets are submitted to their office. I understand that I will be responsible for any childcare costs incurred should timesheets be submitted past 30 days. Timesheets will only reflect hours for which I am at work, training or school. The timesheet must document the in and out times for each day that my child is in the care of my approved provider. Timesheets must be signed by the parent and the provider and be signed and dated no earlier than the last day services are rendered. I understand that if I fail to adhere to the recordkeeping standards for this program, LTBB reserves the right to refuse payment for childcare services and I may be terminated from the program for failure to comply.

I HAVE READ AND UNDERSTAND THIS FORM

SIGNATUE_____ **DATE**_____